Referral Form

Date of Referral _____

Please Include the Following Requirements:

1. Referral Page
2. Substance Abuse Assessment – Most Recent
3. Contact Phone Number
4. Current Valid Driver's License/State ID – Send Copy

Full Name: _____ _____ _____
Last *First* *M.I.* *Age* *Date of Birth*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

County of Legal Residence: _____ Social Security No.: _____ Marital Status: _____

Race: _____ Hispanic: YES ☐ NO ☐ Veteran: YES ☐ NO ☐ # of Dependents: _____

Education Level: _____ Annual Gross Income: _____ Income Source: _____

SSI/SSDI Eligible: YES ☐ NO ☐ Insurance: YES ☐ NO ☐ EPC or MHB: YES ☐ NO ☐ Suicide Attempts in Last 30 Days: YES ☐ NO ☐

Prior to Treatment Living Arrangements: ALONE ☐ W/RELATIVES ☐ W/NON-RELATED ☐ Type of Residence: _____

Legal Status: _____ # of Arrests in Last 6 Months: _____ IV Drug User: YES ☐ NO ☐

Mental Health Diagnosis (Specify): _____

Medications: _____

Dr.'s Appointment or Refill Instructions: _____

	1st Drug of Choice		2nd Drug of Choice		3rd Drug of Choice	
Name of Drug						
Age of 1st Use/Date Last Use						
Use in Past Month/How Often?	YES ☐ NO ☐		YES ☐ NO ☐		YES ☐ NO ☐	
Volume/Per Day, Week, or Month						
Route (Oral/Nasal/Smoke/IV)						

# of Prior Treatment Episodes: _____ Admission Date: _____ Expected Discharge Date: _____

Referred By (Counselor): _____

Form Revised February 2014

Referral Taken By: _____